| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155666 | A. BUILDING 00<br>B. WING | 06/02/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESLEY HEALTHCARE | 1751 WESLEY ROAD<br>AUBURN, IN46706 |

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| F0000 | This visit was for the investigation of Complaint Number IN00090323.<br><br>Complaint Number IN00090323 unsubstantiated due to lack of evidence.<br><br>Unrelated deficiency is cited.<br><br>Survey dates: June 1, 2, 2011<br><br>Facility number: 000307<br>Provider number: 155666<br>Aim number: 100285660<br><br>Survey team:<br>Ann Armey, RN, TC<br>Ellen Ruppel, RN<br><br>Census bed type:<br>SNF/NF: 42<br>Total: 42<br><br>Census payor type:<br>Medicare: 5<br>Medicaid: 30<br>Other: 7<br>Total: 42<br><br>Sample: 5<br><br>This deficiency also reflects state findings cited in accordance with 410 IAC | F0000 | This plan of correction is prepared and executed because of the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the survey allegations. Wesley Healthcare Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character so as to limit our capability to render adequate care.Wesley Healthcare center further maintains that the allegations set forth herin do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facilities credible allegation of compliance.Wesley Healthcare Center requests paper compliance for F0282, as corrective action was taken immediately and this was found to cause no actual harm. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | 16.2.<br><br>Quality review completed 6/5/11<br>Cathy Emswiller RN | | | |
| F0282<br>SS=E | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on observation, interviews and record review, the facility failed to ensure 1 of 4 licensed nurses followed facility policy and professional standards of practice in medication preparation and administration. (LPN #2). This deficit practice affected 8 residents whose medications were to be administered by LPN# 2 on 6/1/11. (Residents B, C, H, I, J, K, L and M).<br><br>Findings include:<br><br>The clinical record of ventilator dependent Resident C was reviewed, on 6/1/11 at 10:00 a.m. The Medication Administration Record (MAR) for June 2001, was | F0282 | 1. Nurse was suspended X3 days then terminated prior to the end of the suspension2. All Nurses in-serviced on Facility policy that all medications are to be prepared and administered as per the rights of med administration and are to be administered within 1hr of the med pass times. They are not to be "set up" or prepared prior to the time of administration.3. DON or designee to monitor nurses for compliance with medication pass procedure 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months.4. QA to follow x 6 months | 06/03/2011 |

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| | reviewed for current medications at 10:05 a.m., and the initials of LPN#2 indicated all the medications for the entire 12 hour shift had been given. These included the resident's 4:00 p.m. dose of Provera 10 mg (a hormone), a 2:00 p.m., dose of alprazolam .25 mg (for anxiety), a 12 noon oral swab of nystatin mouth care (an antibiotic), a 5:00 p.m., dose of methylphenid 20 mg (a central nervous system stimulant), and the 12 noon flush of 200 cc of water for the resident's gastrostomy tube. Review of the narcotic sign out record indicated the alprazolam had been signed out as given.<br><br>Review of additional MARS on the medication cart being used by LPN#2 indicated 7 additional residents' medications had been signed out for the 12 hour shift on 6/1/11. These included: Resident B's 2:00 p.m., dose of Elixophyllin (a bronchodilator), a 4:00 p.m., dose of Buspar (for anxiety), a 2:00 p.m., dose of | | | |

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| | docusate stool softener, a 2:00 p.m., dose of Tramadol (pain medication) and a 2:00 p.m., dose of Provera.<br><br>Resident H's medications of Coumadin at 5:00 p.m., diltazem (blood pressure medication), and hydralazine (for hypertension) scheduled for 4:00 p.m., were signed as given.<br><br>Resident I's medications of Neurontin (an anticonvulsant) and Prostat (dietary supplement) for 2:00 p.m., were signed as given.<br><br>Resident J's 2:00 p.m., iron medication and 5:00 p.m., Coumadin (for blood thinning) were signed.<br><br>Resident K's Neurontin for 2:00 p.m., was signed.<br><br>Resident L's Heparin (blood thinner) was signed as having been given at 4:00 p.m.<br><br>Resident M's Clonazepam (an | | | |

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| | anticonvulsant) for 2:00 p.m., was signed.<br><br>The Director of Nursing (DON) summoned LPN#2 at 10:10 a.m., on 6/1/11 and queried her about all of the medications for the 12 hour shift being signed as given. LPN #2 indicated she had pre-poured the medications for the entire shift because she thought she might get behind during the day. She opened the top drawer of the medication cart and plastic medication cups with various pills were observed in the cups. The cups had been labeled with resident's initials. The individual medications were not identified. She indicated she had also signed the MARs for all the medications and signed out the scheduled drugs from the narcotic box. A count of narcotics with the DON, indicated the count was correct with the afternoon doses having been removed from the containers in the locked narcotic box. | | | |

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| | The facility policy, dated 4/26/10, for medication administration, provided by the DON on 6/1/11 at 12:45 p.m., indicated "Medications are not to be 'set up' or prepared prior to the time the medication is to be administered."<br><br>The current, undated pharmacy policy from (name of pharmacy documented) entitled "Medication Administration" was provided by the DON, on 6/1/11 and indicated in part: "Pre-pouring medications is not permitted." It also indicated, "It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration."<br><br>During interview on 6/1/11 at 12:00 noon, the DON indicated the pre-poured medications had been destroyed and the policy for dispensing and signing would be followed for the resident's whose medications were in LPN#2's | | | |

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| | medication cart.<br><br>3.1-35(g)(2) | | | |